Caring Smiles
You'll love our care and your smile will show it!

Patient Registration

Personal Information:

Full Name: _____ **Preferred Name**: _____
Home Address: _____ **Gender**: Male Female
City, State, ZIP Code: _____ **Birth date**: _____
Home Telephone: _____ **Responsible Party**: _____
Referred by: _____ **Cell Phone**: _____
Social Security Number: **Name of Spouse**: _____
Marital Status:
Employer Name: _____ **Occupation**: _____
Employer Address: _____ **Work Phone**: _____
City, State, ZIP Code: _____
Name, Address, and Phone number of person to call in emergency:

_____

Financial Information:

Primary Insurance (Dental): _____ **Secondary Insurance (Dental)**: _____
Group Number: _____ **Group Number**: _____
Name of Insured: _____ **Name of Insured**: _____
Birth Date: _____ **Birth Date**: _____
Social Security Number: _____ **Social Security Number**: _____

I understand that I am financially responsible for the entire amount of my dental services. Payment may be made by cash, check, or credit card. Payment is due at the time of service unless other financial arrangements have been documented in my chart. A claim will be filed with my insurance company. I am responsible to pay any amount that the insurance does not pay. I authorize the release of any information necessary to process my insurance claim.

_____ _____
Signature **Date**

Consent:

The undersigned hereby authorizes Dr. Kenneth B. Allen, DDS, his associates, and dental staff to perform all necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patient's dental and oral-facial needs including x-rays, study models, photographs, medications, and the use of local anesthetic agents.

_____ _____
Signature **Date**